

# Can we implement ethnic monitoring in primary health care and use the data?

## A feasibility study and staff attitudes in North East England.

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### Abstract

*The concept of ethnic monitoring has evolved over time as a consequence of growing concern around variations in health status and health service utilisation between the different ethnic groups in Britain. Unfortunately, the 1990 proposal of the Department of Health that patients' ethnicity be stated in GP referral letters from 1992 was not implemented. Ethnic monitoring in hospitals was introduced from April 1995 but has not been satisfactorily achieved. This study tested the feasibility of collecting data on patients' ethnicity in general practice and its inclusion in GP referral letters. It also assessed the acceptability of ethnic monitoring in primary care.*

### Keywords

*Ethnicity, monitoring, implementation, general practice*

### Introduction

Primary care is, arguably, the most efficient place for collecting comprehensive data on the ethnicity of the population<sup>1</sup>. In 1990, the Department of Health proposed that from 1992 patients' ethnicity should be stated in GP referral letters<sup>2</sup>. The rationale was that ethnic group data would be collected at the patient's first point of contact with the National Health Service (NHS) and eventually be stored on the 'old' family health service authority (FHSA) database<sup>3</sup>. This would then be available as the patient made contact with different parts of the NHS. Instead, recording of the ethnicity of patients was introduced nationally for hospitalised patients from April 1995<sup>4</sup>. This has not been successful and there may be need to return to the original proposal. However, for such an important issue, there has been surprisingly little published research in the UK. Although one study suggests that acceptability of ethnic monitoring in primary care may be poor in areas with high refugee population<sup>5</sup>, another<sup>6</sup> and anecdotal evidence<sup>7,8</sup> have demonstrated the feasibility and acceptability of the proposal.

We used a multiphase approach to assess the feasibility of ethnic monitoring in primary care in Teesside, where about 1.9% of the population are from ethnic minority groups<sup>9</sup>. We tested the feasibility of collecting data on patients' ethnicity in general practice and, for the first time, the inclusion

of such data in GP referral letters. We further interviewed general practitioners and practice managers to identify opportunities and barriers for its implementation in primary care in Teesside.

### Methods

#### *Collection of ethnic group data*

Two practices (now called A and B) were selected because their practice population size and the proportion of their patients from ethnic minority groups were average for Teesside and their willingness to participate. All registered patients making appointments or arriving as emergencies in the practices for the first time from 1 August 1995 to 31 January 1996 were included. Reception staff gave them ethnic grouping forms to complete while waiting for consultation. Ethnic grouping was based on the classification used in the 1991 census. Practice staff transferred ethnic group data into the practice information system using the Read Code system.

#### *Audit of GP referral letters*

In practice A, reception staff were asked to include ethnic group data in GP referral letters, while in practice B an ethnic group field was added to the existing referral letter template in the practice computer system. We tested the inclusion of these data in referral letters by auditing all referral letters sent out from the two practices in June 1996, and determined the proportion of letters which contained patients' ethnicity.

#### *Attitude survey*

We selected eight practices in the area by stratified random sampling to get a broadly representative sample. We used Tees Health Authority Final Capitation Report for the quarter ending 1 April 1996 as the sampling frame and stratified in terms of size of practice (three or more GPs or fewer) and level of deprivation (based on number of patients in underprivileged areas). This quarterly report, which is a statutory requirement of the 'old' FHSA<sup>10</sup>, contains a list of all doctors by practice, the number of patients on each doctor's list and the number of patients in underprivileged areas

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by doctor. This stratification produced four groups of practices - low deprivation/small sized, low deprivation/ large sized, high deprivation/ large sized, and high deprivation/ small sized. We selected two practices from each of these four groups using random numbers. We interviewed one general practitioner (chosen randomly where there was more than one in a practice) and the practice manager from each practice.

Using semi-structured questionnaires, we elicited respondents' perceptions of the size of the ethnic minority population in their practice, and their awareness of issues around ethnicity and health including ethnic monitoring and attitudes towards its implementation across Teesside. We piloted the method in two practices. OS conducted all interviews taking notes during the interviews and analysed the contents of the transcripts in terms of the themes from the interviews. We also summarised the responses to the main themes as Yes or No.

Results

Collection of ethnic group data

The total number of patients on the list of practice A was 4119 while that for practice B was 7675. During the period of data collection, 2559 patients were seen in practice A and 4096 in practice B. In practice A, no patient refused to indicate their ethnicity but more than one-third of patients were missed. (Table 1) In practice B, only 5 patients refused to indicate their ethnicity and about one-fifth of patients were missed.

Audit of referral letters

Overall, of the 181 referral letters from the two practices, 160 (88.4%) had the patients' ethnic group data specified (including whether patient's ethnicity was known or unknown). In practice A, 69 (76.7%) of 90 letters and all 91 letters in practice B had the field specified. However, 39 (42.9%) of these were coded "unknown" because their ethnic group data had not yet been collected and recorded.

Attitude survey

All the eight GPs and eight practice managers were interviewed. Table 2 summaries the responses to some of the questions raised during the interviews. Five respondents (all GPs) were aware of pilot studies of ethnic monitoring in primary care across the country. All the respondents felt that ethnic monitoring was practicable in

primary care and acceptable to them. When presented with the findings and conclusions of Pringle and Rothera<sup>6</sup>, they did not change their views despite a conclusion that recording adds up to a considerable commitment for practices. They all felt that ethnic monitoring in primary care will help identify use of services, identify gaps in service provision, target effective health promotion and prevention programmes and guide provision of services to meet needs. All were concerned about the danger of this being another data collection exercise if there are no incentives and support from the Health Authority to encourage use of data to plan services. This kind of support was also noted to be essential if the potential benefit to improve service provision was to be realised. The need to raise awareness amongst patients was highlighted by one respondent to "remove the possible suspicion of a hidden agenda by some patients".

All respondents thought it would be more beneficial to implement ethnic monitoring across the whole area rather than in selected practices. One respondent said:

*"I would have said implement in selected practices but I appreciate that it may bring about issues around discrimination, so implementation across Cleveland may be better".*

Respondents perceived that comprehensive monitoring would produce a district-wide picture of ethnic mix of all practices in Cleveland, be useful in planning of services centrally, prevent segregation of facilities and services, and ensure that patients are not limited in their choice of general practitioners. They felt district-wide monitoring should be useful in making services available where needed. Other issues raised included the need for incentives to encourage compliance especially among reluctant practices, the need for training of staff, the value of an awareness campaign and education of the patient population before implementation. Most respondents did not perceive large cost implications.

	Practice A	Practice B	Both practices
	n = 2559	n = 4096	n = 6655
Patients refusing	0 (0)	5 (0.1)	5 (0.1)
Patients without ethnic code on PIS	962 (37.6)	709 (17.3)	1671 (25.1)

Table 1. Number (percentage) of patients who refused to complete ethnic grouping form, and had no ethnic group data on practice information system (PIS) .

Question	Number of responses (%) n=16
	Yes
1. Are you aware of ethnic monitoring in primary care?	5 (31)
2. Do you think that ethnic monitoring is practicable in primary care and will be acceptable to you?	16 (100)
3. Do you think that GPs may benefit from ethnic monitoring?	16 (100)
4. Do you think that patients may benefit from ethnic monitoring?	16 (100)
5. Do you feel that provision of health care services may improve with ethnic monitoring?	16 (100)
6. Do you support the implementation of ethnic monitoring in primary care across all Cleveland?	16 (100)

Table 2. Summary of responses of practice staff to interview questions

## Discussion

There are gaps in the information available on the health status, and the utilisation, of health services by ethnic groups<sup>11</sup>. Ethnic monitoring is expected to fill such gaps and to encourage a focus on the health needs of local minority populations. In geographical areas where the ethnic minority population is small, there is particular danger of isolation and disadvantage in terms of equity and access to health care services. Showing that ethnic monitoring can be done in such areas is particularly important.

We have demonstrated that ethnic group data can actually be collected and, for the first time, be used to inform hospitals. The high compliance achieved when a field was created in the referral letter template shows the power of automation using computer technology. When approached by staff, nearly all patients were agreeable to providing ethnic group data. Practice staff explained that most of the missed patients came to surgery either as emergencies or without appointments, but they could not quantify this. Our findings may be generalisable but further research should be done.

The support for ethnic monitoring found in our attitude study, from an area with low prevalence of ethnic minorities, is particularly important for considering national implementation of ethnic monitoring in primary care and presents a strong case for local implementation, at least, by the Primary Care Groups (PCGs) in Teesside. The practical issues of implementation identified in this survey are similar to those reported by Pringle and Rothera<sup>6</sup>.

As yet, there is no direct evidence of the benefits and cost-benefits of ethnic monitoring but there are examples of use of ethnic group data in primary care including continuing pilot studies in Birmingham and Coventry. However, on first principles, the potential benefit of ethnic monitoring in primary care may be more than in hospitals because the majority of the population has contact with primary care services, giving an opportunity for comprehensive data collection. Opportunities to promote health rather than treat diseases may be more realistic with primary care ethnic monitoring. There is therefore a case for rigorous evaluation of routine ethnic monitoring in primary care. Since implementations have been carried out in the context of research, there will be need to consider resource implication in the context of routine service.

These data add to other studies<sup>5,6</sup> and invite a reconsideration of the Department of Health's 1990 proposal. Ethnic monitoring can start in primary care rather than in hospitals<sup>3,6</sup>. This is more relevant now than in 1990<sup>2</sup> as the responsibilities of primary care and primary care groups/trusts (PCGs/PCTs) have increased enormously since then.

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